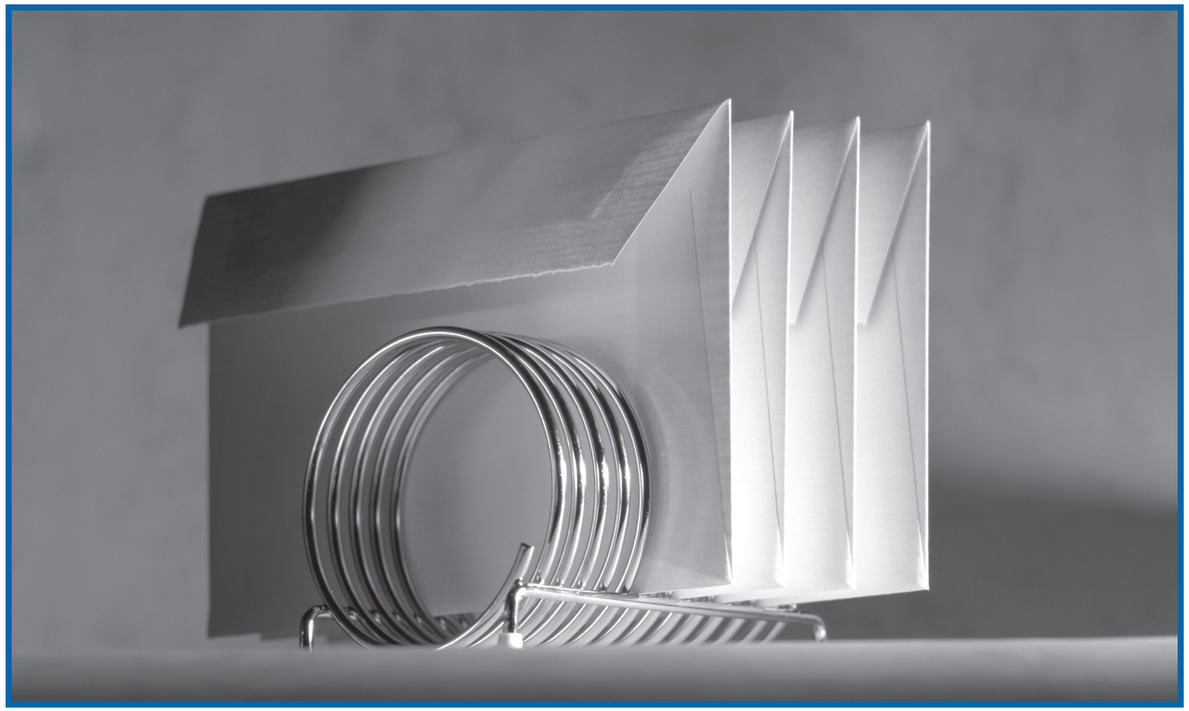
Your Summary EOB gives you all the answers you need!

South Carolina

15154

How much did your health plan pay?

How much do you owe?



UNDERSTANDING YOUR SUMMARY EXPLANATION OF BENEFITS (EOB)

Your Summary Explanation of Benefits, or Summary EOB, gives the status of your health claims. Your health plan produces a Summary EOB every 21 days. This EOB provides information for claims processed for all individuals under your member ID during the 21-day period. If there are no claims, you won't receive a Summary EOB for that period.

Your Summary EOB gives you all the information you need concerning your health claims — and we've made it easy to read and understand. The summary section outlines the costs your health plan has covered and the amounts you owe specific providers. It also provides information on other payments made to providers on your behalf (through another health plan, insurance company or Medicare, if applicable). And we've included definitions of some terms and an explanation of your appeal rights.

The claim(s) detail section provides more information about each claim, such as charges, allowed amounts and coinsurance. It also explains where you stand on deductible and out-of-pocket amounts.

This brochure will walk you through a typical Summary EOB line-by-line to make understanding your benefits easier. Keep it with your family's medical documents for quick reference anytime.

We hope you find the Summary EOB helpful and a convenient way to organize information regarding your medical bills.

South Carolina

Summary Explanation of Benefits (EOB)

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

March 20, 2007 ***

This is not a bill. Any amounts you may owe your provider should not be sent directly to us.

JOHN DOE
PO BOX 0000
ANYWHERE, SC 12345

1 SUMMARY EXPLANATION OF BENEFITS
Claims Processed from 02/27/07 to 03/19/07

This summary information is for claims processed for patients covered under Member ID 2 ZWC999999999999 . You will also find claim(s) details. We produce this report every three weeks. If you have questions about your claims, please visit our Web site at www.SouthCarolinaBlues.com or call Customer Service at 1-800-760-9290 OR LOCALLY AT 788-0500 Mon. – Thurs. 8:00 A.M. – 6:00 P.M. and Fri. 8:00 A.M. – 4:30 P.M. 3

This document outlines your share of the charges for services. You should use this to determine how much you need to pay. If there is a discrepancy, use this summary to discuss the charges with your provider.

4 **Name: JANE DOE** 5 **Patient Relationship to Policyholder: SPOUSE**

6 **Amount We Paid Your Provider(s):**

COOK	267.89
SMITH PHARMACY	.00
FAMILY PRACTICE	23.35

7 **Your Other Insurance Company Paid:** 160.16

8 **Medicare Paid:** 58.20

9 **Amount Your Provider(s) May Bill You:**

COOK	.00
SMITH PHARMACY	24.18
FAMILY PRACTICE	34.80

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Suspect claims fraud? Please help us by calling our hotline at 1-800-763-0703.

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Helpful Definitions

Amount Not Covered – the amount, if any, for non-covered services or the amount that is above the allowed charge. Please refer to the remarks on the Summary Explanation of Benefits Claim Details section.

Amount Paid to You – the amount we paid you, based on your health plan.

Amount Paid to Your Provider – the amount we paid your provider, based on your health plan.

Amount Your Provider May Bill You – the amount, if any, you need to pay the provider for this claim. There may be times when you owe nothing.

Amount We Paid – the amount paid by your health plan for the services you received.

Allowed Amount – the amount remaining after any non-covered, deductible or copayment amounts have been subtracted from the amount your provider charged. Your coinsurance, if applicable, will be determined from the allowed amount.

Benefit Period – the period of time during which you must pay any deductible and coinsurance payments that may apply. Payment of claims begins once you meet the deductible. If you reach your out-of-pocket amount and deductible limits, we pay covered expenses in full for the rest of the benefit period, minus any copayments. Deductibles and coinsurance start over with each new benefit period.

CDHP (Consumer Driven Health Plan) Paid – the amount paid from your Health Reimbursement Account, if applicable.

Coinsurance – the percentage of the allowed amount you pay as your share of the bill. If your health plan pays 80%, then 20% would be your coinsurance.

Copayment – a set fee you pay each time you receive a certain service. Some health plans or services do not have copayments.

Deductible – the amount, if any, you are responsible for paying before any amount is payable under your health plan. You do not send this amount to us. You must pay this to your provider. We credit you as having paid your deductible on the claims you and providers send to us.

Out-of-pocket Maximum – the highest total amount of coinsurance you will have to pay during a benefit period.

Other Insurance Paid – the amount paid by another insurance company toward services you received.

When Medicare Applies

Medicare Approved AMT (Amount) – the amount Medicare approves for services you received.

Medicare Paid – the amount Medicare paid toward services you received.

Total Benefit Allowed – the amount we would have paid if another insurance company were not involved.

11 **APPEAL OR REVIEW**

If you disagree with the disposition of this claim, you may request a review or appeal within 180 days from the date of this notice. Your request for review or appeal must be in writing. You may submit written comments, documents, or other information in support of your appeal or review, and you will have access to all documents that are relevant to your claim. If your plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), you may have the right to bring a civil action under ERISA following your appeal or review. Please check your health plan and booklet for more specific information regarding your appeal or review.

Here's how to contact us:

BLUECROSS BLUESHIELD OF SOUTH CAROLINA
P. O. BOX 100300
COLUMBIA, S.C. 29202-3300

12 **THIS IS A NEW EXPLANATION OF BENEFITS CALLED THE SUMMARY EOB. WE PRODUCE A SUMMARY EVERY 21 DAYS TO SHOW ANY CLAIMS PROCESSED DURING THAT TIME. IF THERE ARE NO CLAIMS, YOU WILL NOT RECEIVE A SUMMARY EOB FOR THAT PERIOD.**

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1 **Claims Processed from (date) to (date)** — The 21-day period covered by the Summary EOB.

2 **Member ID Number** — The covered member's number. Please have this number handy if you need to call Customer Service.

3 **Customer Service Information** — If you have a question about your health plan or the information on your Summary EOB, here's how to contact us.

4 **Patient's Name** — The name of the person who received a service.

5 **Patient Relationship to Policyholder** — This is the patient's relationship to the member.

6 **Amount We Paid Your Provider(s)** — The total amount your health plan paid your provider, based on the terms of your health plan.

7 **Your Other Insurance Company Paid** — If you have other insurance coverage, the total amount it paid toward services you received.

8 **Medicare Paid** — When Medicare applies, the total amount Medicare paid toward services you received.

9 **Amount Your Providers May Bill You** — The total amount, if any, you need to pay the provider for this claim(s). There may be times when you owe nothing.

10 **Helpful Definitions** — We've included some definitions to help you better understand your Summary EOB.

11 **Appeal or Review Information** — How to file an appeal if you disagree with your health plan's coverage decision.

12 **Important Messages** — Tips for becoming a wiser health care consumer, as well as other important messages.

13 **General Claim Information** — Patient name and member ID number, patient's relationship to policyholder, claim number, provider name and whether the provider participates in our network. Claims are grouped by patient on the Summary EOB.

14 **Date(s) of Service** — When a patient received services.

SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

This is important information about services JANE DOE received. The following information shows how much we covered and how much you may owe your provider for services received.

13 Patient: **JANE DOE** ID: **ZWC999999999999** **Patient Relationship to Policyholder: SPOUSE**

Claim Number: **6A7000000-00-00** Provider: **COOK** *Participating Provider* Date(s) of Service: 03/04/07 14 Amount Provider May Bill You: **.00** 15

Your Provider Charged	Amount Not Covered*	Deductible	Copayment	Allowed Amount	Coinsurance	Other Insurance Paid	Amount We Paid	CDHP Paid	Amount Paid to Your Provider
16 227.50	17 45.67 (1)	18 .00	19 20.00	20 161.83	21 .00	22 54.34	23 107.49	24 20.00	25 127.49
308.00	144.76 (1)	.00	.00	163.24	.00	73.57	89.67	.00	89.67
135.00	52.02(1)	.00	.00	82.98	.00	32.25	50.73	.00	50.73
TOTAL:									
670.50	**242.45**	**.00**	**20.00**	**408.05**	**.00**	**160.16**	**247.89**	**20.00**	**267.89**

26 To date, you have satisfied 100.84 of the 500.00 deductible for the benefit period that began 01/01/2007 . This claim contributed .00 toward your out-of-pocket maximum. You have satisfied .00 of the 1,500.00 out-of-pocket maximum for this benefit period. We paid a total of 247.89 for this person this benefit period. 27

Claim Number: **6B7000000-00-00** Provider: **SMITH PHARMACY** Date(s) of Service: 03/12/07 Amount Provider May Bill You: **24.18**

Your Provider Charged	Amount Not Covered*	Deductible	Copayment	Allowed Amount	Coinsurance		Amount We Paid		Amount Paid to You 28
24.18	.00	24.18	.00	.00	.00		.00		.00

To date, you have satisfied 125.02 of the 500.00 deductible for the benefit period that began 01/01/2007 . This claim contributed .00 toward your out-of-pocket maximum. You have satisfied .00 of the 1,500.00 in network out-of-pocket maximum for this benefit period.

Claim Number: **6D7000000-00-00** Provider: **FAMILY PRACTICE** *Participating Provider* Date(s) of Service: 03/13/07 Amount Provider May Bill You: **34.80**

Your Provider Charged		Medicare Deductible	Medicare Coinsurance	Total Benefit Allowed	Medicare Approved AMT	Medicare Paid	Amount We Paid		Amount Paid to Your Provider
130.00		.00	26.00	29 105.00	30 72.75	31 58.20	14.55		14.55
44.00		.00	8.80	35.00	8.80	.00	8.80		8.80
TOTAL:									
174.00		**.00**	**34.80**	**140.00**	**81.55**	**58.20**	**23.35**		**23.35**

To date, you have satisfied 125.02 of the 500.00 deductible for the benefit period that began 01/01/2007 . This claim contributed 34.80 toward your out-of-pocket maximum. You have satisfied 34.80 of the 1,500.00 in network out-of-pocket maximum for this benefit period.

32 *** REMARKS:**

(1) THIS AMOUNT EXCEEDS THE MAXIMUM ALLOWABLE AMOUNT FOR THIS SERVICE.

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15 **Amount Provider May Bill You** — The amount, if any, you need to pay the provider for this claim. There may be times when you owe nothing.

16 **Your Provider Charged** — The amount the provider charged for the services.

17 **Amount Not Covered** — The amount, if any, for non-covered services or the amount that is above the allowed charge. Please refer to the remarks on the Summary Explanation of Benefits Claim Details section.

18 **Deductible** — The amount, if any, you are responsible for paying before any amount is payable under your health plan. You do not send this amount to us. You must pay this amount to your provider. We credit you as having paid your deductible on the claims you and providers send to us.

19 **Copayment** — The set fee you pay each time you receive a certain service. Some health plans or services do not have copayments.

20 **Allowed Amount** — The amount remaining after any non-covered, deductible or copayment amounts have been subtracted from the amount your provider charged. Your coinsurance, if applicable, will be determined from the allowed amount.

21 **Coinsurance** — The percentage of the allowed amount you pay as your share of the bill. For example, if your health plan pays 80 percent, then 20 percent would be your coinsurance.

22 **Other Insurance Paid** — The amount paid by another health plan or insurance company toward services you received.

23 **Amount We Paid** — The amount paid, based on your health plan, for the services you received.

24 **CDHP (Consumer Driven Health Plan) Paid** — The amount paid from your Health Reimbursement Account, if applicable.

25 **Amount Paid to Your Provider** — The amount we paid your provider, based on your health plan.

26 **Deductible and Out-of-pocket Summary** — This area explains how much you have paid toward your deductible, if applicable. It shows how much of this claim went toward your out-of-pocket expenses and how much you've paid toward your out-of-pocket maximum so far this benefit period. It also shows how much we've paid in benefits for the patient during this benefit period.

27 **Benefit Period** — The period of time during which you must pay any deductible and coinsurance payments that may apply. Payment of claims begins once you meet the deductible. If you reach your out-of-pocket amount and deductible limits, we pay covered expenses in full for the rest of the benefit period, minus any copayments. Deductibles and coinsurance start over with each new benefit period.

28 **Amount Paid to You** — The amount we paid you, based on your health plan.

29 **Total Benefit Allowed** — The amount we would have paid if another health plan or insurance company were not involved.

30 **Medicare Approved AMT** — When Medicare applies, the amount Medicare approves for services you received.

31 **Medicare Paid** — When Medicare applies, the amount Medicare paid toward services you received.

32 **Remarks Section** — This section explains any remarks included on your Summary EOB.

33 **Number of pages** — The number of claims processed during this time period for you, your spouse and any dependents will determine the number of pages for each Summary EOB.